costs shall submit source documentation demonstrating the total amount of field security costs incurred and the Title XIX fee-for-service program's share of such costs.

3. If the Title XIX total fee-for-service payment under the service-specific statewide unit rates in the aggregate is greater than 90 percent but less than or equal to 100 percent of the allowable cost, reimbursable cost is equal to the Title XIX fee-for-service payment based on the service-specific statewide unit rates.

Effective January 1, 2000, the reimbursement methodology is the lesser of either the reasonable and customary charges or the service-specific statewide unit rates, based upon a prospective per unit methodology. The service-specific statewide per unit rates will be incrementally adjusted each January 1, beginning on January 1, 2000, using Standard and Poor's DRI Home Health Market Basket Index.

The unit of service shall be a 15 minute interval of a skilled nursing visit, a home health aide visit, a speech therapy visit, a physical therapy visit, an occupational therapy visit, or a medical ~~social~~ service visit. The home health agency may bill one unit of service for each full 15 minute interval of face-to-face service in which hands-on medical care was provided to a Medicaid or NJ KidCare fee-for-service beneficiary. Routine supplies shall be considered visit overhead costs and billed as part of a unit of service. Non-routine supplies are billable and will be reimbursed in accordance with the fees established.

Out-of-State Approved Agencies

For services rendered on or after January 1, 1999, out-of-state home health services shall be reimbursed using the lesser of either the reasonable and customary charges or service-specific statewide unit rates, based upon a prospective per unit methodology. No cost filing is required and no retroactive settlement shall be made.

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DURABLE MEDICAL EQUIPMENT (DME)

There are four (4) methods of reimbursement for durable medical equipment furnished to Medicaid patients. These methods are purchase, rental, repair and recycling. The decision on which method is appropriate depends on several factors, including, but not limited to, cost of the DME, the patient's medical need for the DME, and the length of time they will need the DME.

1. Purchase Policy

(a) Medical equipment items shall be purchased when the medical need will exist for a period of time long enough to make purchases more economically practical than rental.

(b) Payment for purchase is made by one of the following methods:

I. If there is a Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public or the Medicaid fee allowance established by the Medicaid program.

II. If there is no Medicaid fee schedule, payment shall be based on the lesser of the provider's usual and customary charge to the general public or a calculated maximum fee allowance equal to either 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's list price for supplies or equipment.

Note: In no event shall the purchase price described above exceed the lowest payment allowed by Medicare.

(c) When vaporizers or cool mist humidifiers are purchased, they shall be reimbursed based on the payment methods described in (b) above.

2. Rental Policy

Payment is calculated at one hundred twenty (120) percent of the approved purchase price. The following policies also apply:

(a) If the approved purchase is $100.00 or over, monthly rental is twelve (12) percent of this price. After ten (10) monthly payments, equipment is considered purchased and paid in full.

(b) If the approved purchase price is less than $100.00, monthly rental is twenty (20) percent of this price. After six (6) monthly payments, equipment is considered purchased and paid in full.

(c) Used DME is reimbursed in the same manner but calculated on a fair market value of used items.

(d) If a rented item is purchased before the rental to purchase conversion time is reached, payment is based on the difference between the sum of rental payments previously paid and the approved purchase price.

i. Respiratory equipment such as ventilators, respirators, etc., are not purchased according to the rental to purchase policy. (See (d) above.)

3. Repair Policy

(a) Medical equipment items may be repaired and suppliers reimbursed for replacement parts and/or labor charges when the medical need for the item will continue to exist for a period of time and repair is more economical than purchase.

(b) Payments for repairs are generally allowed at a rate established by the Medicaid program. Providers will be reimbursed their usual and customary price for replacement parts.

4. Recycling Policy

(a) Recyclable DME which includes, but is not limited to commodes, communication devices, durable bathroom equipment, hospital beds, walkers, and wheelchairs and wheelchair components, is reimbursed at a sliding scale percentage of reimbursement costs of new equipment. This reimbursement includes pick-up, cleaning, repair, storage, and delivery.

(b) Medical equipment shall be recycled by a recycling contractor when the aggregate cost to recycle does not exceed the Medicaid maximum fee allowance for new equipment.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

DURABLE MEDICAL EQUIPMENT

Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any other third party payments).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

INDEPENDENT CLINIC SERVICES

Payment for Independent Clinic Services shall be as follows:

(1) Independent Clinic Services Generally

(a) Reimbursement for covered services in approved independent clinics shall be determined by the Commissioner of the Department of Human Services. Except where a set fee schedule or other rate exists, reimbursement to independent clinics shall be based on the same fees, conditions and definitions, for corresponding services, utilized for the reimbursement of the individual Title XIX participating practitioners and providers in "private" practice.

(b) In no event shall the charge to the Title XIX programs exceed the charge by the provider for identical services to other governmental agencies or other groups or individuals in the community.

(c) Payment for Part B co-insurance and deductible shall be paid only up to the Title XIX maximum allowable (less any third party payments).

(2) Medical Day Care Centers

(a) Medical Day Care Centers in a nursing facility (NF) will be reimbursed at 43 percent of that NF's per diem rate effective October 1, 1990. This is an interim rate.

A Medical Day Care Center in an NF will be reimbursed at 45 percent of that NF's per diem rate as a final rate. The effective date of this rate will be the date of publication of the proposed Medical Day Care Manual in the New Jersey Register. A provision allows for a one-time retroactive adjustment for all Medical Day Care Centers back to October 1, 1990. This adjustment shall be calculated to pay the difference between 43 percent and 45 percent of the NF rate multiplied by the days of service at the 43 percent of the NF rate.

(b) In freestanding Medical Day Care Centers, the medical day care per diem rate is based on 45 percent of an average of the rates paid to nursing facility-based medical day care providers or a percentage of nursing facility rates in effect as of January 1 and July 1 of each year.

(c) For hospital-affiliated Medical Day Care Centers, the medical day care rate is a negotiated per diem rate which shall not exceed the maximum medical day care per diem rate paid to NF-based providers.

(3) Ambulatory Surgical Services--Effective with services rendered on or after November 29, 1991, reimbursement for ambulatory surgical services in an approved ambulatory care center will be based on an all inclusive fee(s) for each approved surgical procedure. If more than one surgical procedure is performed on a patient in a single operative session. payment si limited to two procedures, provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will be at 50 percent of the applicable reimbursement rate for that procedure.

(4) Ambulatory Surgical Services provided by an ambulatory care/family planning/surgical facility licensed and authorized by the New Jersey Department of Health shall be as follows:

Reimbursement for ambulatory surgical procedures will be based on an all inclusive fee schedule established by the Commissioner. If more than one surgical procedure is performed on a patient in a single operative session, payment is limited to two procedures,s provided that the second procedure is at a separate operative site on the patient. Full payment will be made for the procedure with the highest reimbursement rate. Payment for the other procedure will abe at 50 percent of applicable reimbursement rate for that procedure.

(5) Narcotic and Drug Abuse Treatment Centers -- Reimbursement for narcotic and drug abuse treatment centers will be on a fee-for-service basis. Reimbursement will be limited to those services eligible for federal financial participation under Title XIX.

(6) Out-of-State Clinics--Payment to out-of-state clinics shall be the same as for in-state clinics, depending on the service provided.

7) HealthStart Providers--

(a) Independent clinics, including local health departments, that are fre standing, licensed and certified ambulatory care clinics may provide all HealthStart services. They will be reimbursed on a fee-for-service basis using HCPCS codes developed for HealthStart.

(b) Independent clinics, which are local health departments, and which have been certified by the New Jersey Department of Health as HealthStart Pediatric or HealthStart Support Services providers, will be reimbursed on a fee-for-service basis using HCPCS codes developed for HealthStart.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Services

INDEPENDENT CLINIC SERVICES

Independent Clinic (8) - Injectables

Immunizations:

Reimbursement for immunization services will be based on the formula of Average Wholesale Price (AWP) of the pharmaceutical plus 15 percent, plus $2.00 for the physician's cost of dispensing the immunization.

Other Physician-Administered Injectables and Inhalation Drugs:

Reimbursement of approved Level III HCPCS codes for injectable and inhalation drugs shall be based on (1) the Average Wholesale Price (AWP) of a single dose of an injectable or inhalation drug or (2) the clinic's acquisition cost for the injectable or inhalation drug, whichever is less, when the drug is administered in an independent clinic. The Medicaid maximum fee allowance for these drugs will be adjusted periodically by the program to accommodate changes in the market cost.

Reimbursement for all injectables and inhalation drugs to Federally Qualified Health Centers (FQHCs) is at the encounter rate.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Non-Institutional Services
State of New Jersey
FEDERALLY QUALIFIED HEALTH CENTERS

Independent Clinic reimbursement for Federally Qualified Health Centers (FQHCs) and Qualified FQHCs which are determined by the Secretary of the Department of Health and Human Services will be made at an interim encounter rate with a lump sum reconciliation made at the FQHC's fiscal year end.

The Medicaid FQHC cost report is used to record the total expenses and encounters for all clients (regardless of payer) of an FQHC. Medicare principles of reimbursement of FQHCs are used to determine reasonable costs.

An interim encounter rate shall approximate the reimbursable cost, excluding donation costs related to outstationed eligibility workers, which the FQHC is currently incurring in furnishing covered services to Title XIX eligible beneficiaries.

For those FQHCs that have filed a Medicaid cost report, the interim encounter rate shall be the prior year's encounter rate as calculated from the Medicaid cost report which shall be incremented by the percentage increase in the Medicare Economic Index applicable to primary care physicians' services. The interim encounter rate shall be based upon all reasonable costs not reimbursed by the HCPCS procedure code fees. The interim encounter rate shall be adjusted to approximate the reimbursable cost the FQHC is currently incurring in providing covered services to Title XIX eligible beneficiaries, net of payments for these other billings. In addition, the reimbursement of donation costs related to outstationed eligibility workers will be made on a lump-sum basis once each calendar quarter.

The Division will reimburse Federally Qualified Health Centers (FQHCs) for the difference between reasonable costs and the amounts paid to FQHCs by managed care organizations for services provided to Title XIX eligible beneficiaries. This wrap-around reimbursement will be made on a calendar year quarterly basis after the FQHC submits all required quarterly wrap-around reports.

Based on the FQHC's quarterly wrap-around reports, State staff will compare receipts from the managed care organization to what the FQHC would have received under Medicaid's reasonable cost reimbursement. If the reasonable cost reimbursement is higher than the receipts from managed care organizations, the provider will receive eighty-five (85%) of the difference, subject to interim and final settlements, within thirty days of the receipt of the FQHC's reports. The providers will only receive 85% of the difference to account for unrealized revenues from the HMOs for fee-for-service and other contractual payment arrangements which are due the FQHCs. If the receipts from managed care organizations are higher than reasonable cost reimbursement, the State will initiate recovery of eighty-five percent (85%) of the difference, subject to interim and final settlements, within thirty days of the receipt of the FQHC's reports.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Non-Institutional Services
State of New Jersey

If there is an FQHC obligation after thirty days from the date recovery is initiated, interest will be assessed in accordance with N.J.S.A. § 30:4D-17(e), (f) and N.J.S.A. § 31:1-1(a).

For the FQHCs that have not filed a Medicaid cost report, the interim encounter rate shall be an average of the interim encounter rates described above.

The actual encounter rate will be calculated from the reasonable costs, excluding donation costs related to outstationed eligibility workers, reported on the Medicaid Cost Report. The actual encounter rate will be subject to adjustment based upon any audits of the Medicaid Cost Report.

To test the reasonableness of the productivity of the staff employed by the FQHC, the following guidelines are used:

1. At least 2.1 encounters per hour, per physician;

2. At least 1.1 encounters per hour, per nurse-practitioner or nurse-midwife;

3. At least 1.25 encounters per hour, per dentist or dental hygienist.

Medicaid reimbursement will be based upon the lower of the reasonable costs, excluding donation costs related to outstationed eligibility workers, of services provided to Title XIX eligible beneficiaries or the Medicaid limit per encounter. The Medicaid limit is based on the Medicare annual limitation, adjusted to recognize Medicaid and Title XIX eligible services not covered by Medicare and the possibility that a Title XIX eligible beneficiary may receive a higher intensity of care than a Medicare client.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
Reimbursement for Non-Institutional Services
State of New Jersey

The Medicaid limit will be phased in during the first three years in the following manner:

A) For service periods from July 15, 1996 through July 14, 1997, the Medicaid reimbursement will be 120% of the urban Medicare limitation;

(B) For service periods from July 15, 1997 through July 14, 1998, the Medicaid reimbursement will be 115% of the urban Medicare limitation;

(C) For service periods on and after July 15, 1998, the Medicaid reimbursement will be 110% of the urban Medicare limitation.

The reimbursement for specific administrative costs, as opposed to direct patient care costs, will be limited to thirty percent of the direct patient care costs incurred by an FQHC.

Pneumococcal and influenza vaccine costs will be treated as pass-through costs and will not be subject to screens.

The reasonable costs of receiving the Medicaid billing remittance advice in a personal computer format will be treated as pass-through costs and will not be subject to screens.

If an FQHC is to receive less Title XIX eligible reimbursement per encounter as a result of the proposed methodology, the reduction will be limited to 20% of the prior year's actual encounter rate. This reduction cap will apply until each FQHC's rate is within the payment limit.

A lump sum reconciliation will be made after each FQHC's fiscal year end for the difference between the FQHC's interim total reimbursement from the Medicaid Program and the managed care organizations and the actual allowable costs, excluding donation costs related to outstationed eligibility workers, for services rendered to Title XIX eligible beneficiaries.

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